HHA PPS MAILBOX QUESTIONS

VOLUME IX, September 2001 – Batch 1

The questions below, which in some cases have been paraphrased, were sent to *HHPPSQuestions@HCFA.gov* during the period referenced above. This batch of questions was pulled from the mailbox prior to October 1, 2001. In cases where time is needed to consult internal experts, multiple batches of answers may be released under the same Volume number (same time period or month). Note that questions without broad applicability have been/will be answered/referred individually.

Questions are grouped by topic and not repeated. However, each batch of questions will be listed by topic in order at the beginning of each batch of answers, and a table of cross-references will follow.

List of Home Health Prospective Payment System (HH PPS) Billing Questions, Volume IX, Batch 1:

HH PPS Billing Questions Cross-reference, Volume IX, Batch 1:

Websites (CMS): 6, 9

General Acronyms

The following acronym may not be spelled out/explained above or elsewhere in this document:

CMS = The Centers for Medicare and Medicaid Services, current name of the Federal agency administering Medicare, formerly HCFA
HH = home health
HHA = home health agency
HCFA = Health Care Financing Administration, previous name of the Federal agency administering Medicare. Note: The name of the agency was changed in June 2001 to the Centers for Medicare and Medicaid Services (CMS)
HIPPS = Health Insurance PPS, a code representing a PPS payment group on a Medicare claim, placed in Form Locator 44 of Medicare claims
HCPCS = HCFA Common Procedure Coding System, individual codes representing medical services or items in Form Locator 44 of Medicare claims
POC = Plan of care
RHHI = Regional Home Health Intermediary, a Medicare fiscal intermediary specializing in the processing of home health and hospice claims
SOC = Start of care

VOLUME IX, Batch 1, HH PPS Billing QUESTIONS and ANSWERS

Payment Policy:

Q1 : In answer to question 2 in Volume VI, June 2001 Batch 1 of these questions, you use the words "...meet the two conditions required for a significant change in the condition (i.e. new orders and a change in the payment group)..."

According to the final rule there were three conditions required for a significant change in condition; the two you mention above and multiple references to the fact that the change represented a change not anticipated in the plan of care at admission or recertification. It is stated in various ways in the final rule, including the following: "...not envisioned in the original plan of care..." (p. 41131); "...unanticipated in the context of the initial assessment..." (p. 41145); "...not accounted for in the original plan of care..." (p. 41145); (FEDERAL REGISTER/Vol. 65, No. 128/Monday, July 3, 2000)

Your answer appears to indicate that there are only two conditions to be met for a significant change in condition when the final rule indicates in multiple areas that there is a third condition to be met before a significant change in condition can warrant a possible payment adjustment, that being whether or not the change was anticipated in the original plan of care.

Please correct the information to include the third requirement.

A1: The answer to this question was revised on September 18, 2001. The scenario in that question did not call for a SCIC and the revised answer makes no reference to SCIC criteria. Thank you for helping CMS clarify this policy.

Q2: Are outpatient psychiatric services covered under the home health benefit like outpatient physical therapy?

A2: No. Outpatient psychiatric services are not included in the definition of the home health benefit.

Q3: In your June, 2001, Batch 1 of PPS questions, there is a cross reference to IV/Infusion Therapy that points to #16--however, there is no question 16 in this batch. Am I missing the connection here?

A3: No, you have not missed anything. The cross reference referred to a question that was still being researched at the time the volume VI, batch 1 questions were posted. That particular IV therapy question will be addressed in an upcoming volume VI, batch 2 along with other questions that required further study. The cross reference was not removed when the question was deferred to the later batch. We apologize for this oversight.

Consolidated Billing:

Q4: Please direct me to where on your website we can obtain a copy of the payment rates for the non-routine bundled supplies for home health services.

A4: A list of separate payment rates for non-routine medical supplies under the home health benefit does not exist. Non-routine medical supplies are not paid separately under HH PPS. Prior to HH PPS, separate rates for these supplies did not exist because the services were reimbursed on a cost basis.

Billing:

Q5: If there was a RAP billed and already paid with a higher HIPPS code reflecting projected physical therapy & we did not get our 10 visits in, how do we correct the next bill to reflect this?

A5: You do not need to take any action to account for this situation. Simply submit the final claim for the episode with the original HIPPS code. The Pricer software in Medicare systems will automatically change the HIPPS code and adjust the payment for the claim based on the fact that fewer than 10 therapy visits are reported on the claim.

Q6: I'm looking for a listing of J codes in excel format. Is such a file available for downloading on your site?

A6: A complete Excel file of all alphanumeric HCPCS codes is available for download in ZIP format on the CMS Public Use Files website at www.hcfa.gov/stats/pufiles.htm#alphanu. The file can be found at the first bullet under the "Utilities/Miscellaneous" heading. Using this complete file, a file of just the HCPCS codes beginning with "J" can easily be created by cutting and pasting between worksheets. "J" HCPCS codes are not used on home health PPS claims.

Q7: When a Medicare beneficiary ceases to be eligible for the HH benefit (ex: dressing changes to decubitus ulcer that has no end date) but will remain on service with a payer change to Medicaid for dressing changes, is the patient status code on the final claim 01 or 06? Is agency entitled to full episode payment under Medicare or to a PEP payment since client actually remains on service under another a payer?

A7: The final claim in this case should be submitted with patient status 01, since the patient is discharged from Medicare, not transferring to another HHA (which is the definition of patient status 06). Assuming no other payment adjustment (SCIC or LUPA) would apply, the claim would receive the full episode payment.

Q8: How should I submit a demand bill for visits that last several hours and a portion of the visit is covered by Medicare and the balance of the visit is covered by another payer, such as Medicaid? The physician's order is for a single visit, but since there are two payers involved should I put two lines on the claim to represent the visit, one line covered by Medicare and the other line non-covered?

A8: Since only one visit is provided, you should report only one line item on the claim to represent that visit. Medicare claims systems interpret each line item on a home health claim as a separate visit. Each line is interpreted as a visit because the units field (FL 46) of the line is used to report 15 minute increments.

Report both the total charges for the visit (in FL 47) and the non-covered charges for the visit (in FL 48) on the same line. Report the total elasped time of the visit in fifteen minute increments in FL 46. Medicare demand billing instructions have not addressed this situation in the past, and will be revised in coming weeks to do so. Please note also that a conflict currently exists between the guidance in this answer and CMS Program Memorandum A-01-130 which states "If providers have an instance in which there are covered and non-covered units for a service that could be submitted as a single line item, with this instruction providers will now have to split such submissions into two line items, one with all covered and the other with all non-covered charges." That Program Memorandum will also be revised in coming weeks to create an exception for home health claims that will conform with this answer. Remember that demand bills are submitted reporting condition code 20.

485 and OASIS:

Q9: Will CMS issue a new 485 plan of care form which will reads "Through" instead of "To" for the certification period and if so, when can we anticipate this change.

A9: CMS does not plan to issue a new form 485. However, the instructions for using the 485 have been changed in Program Memorandum A-00-71, published October 2, 2000. The instructions for item 3, Certification Period, state:

"For Dates of Service on or after the effective date of HH PPS (October 1, 2000): The HHA enters the month, day, year, e.g., MMDDYYYY that identifies the period covered by the physician's POC. The "From" date for the initial certification must match the SOC date. The "To" date is up to and including the last day of the episode which is not the first day of the subsequent episode. The "To" date can be up to, but never exceed a total of 60 days that includes the SOC date plus 59 days.

EXAMPLE: Initial certification "From" date 10012000; Initial certification "To" date 11292000; Re-certification "From" date 11302000; Re-certification "To" date 01282001."

This Program Memorandum is available on the CMS website at www.hcfa.gov/pubforms/transmit/A0071.pdf.

Q10: Question 7, Volume V, May 2001, Batch 1 of these questions describes a situation where M0825 response is "YES" at the start of the episode and the patient ends up receiving only 6 therapy visits during the episode. The answer indicates no billing action is necessary since the final claim would automatically be downcoded to reflect less than 10 therapy visits. However, the second paragraph of the answer then states that the HHA should correct the original assessment to reflect a M0825 response of "NO".

This situation does not constitute an "error" on the original assessment. If M0825 was answered with the best information available at the time of the assessment, why would it be subsequently changed to a "NO"? If an HHA is required to change an assessment with a "YES" response to M0825 if less than 10 therapy visits were actually provided during the episode, at what time point is that assessment to be changed?

A10: The original response to question 7 of the volume V, batch 1 that you are responding to was in error. The response to that question was revised on November 1, 2001 to read, in part, "it is not necessary to correct the original assessment at M0825 (i.e. change the Yes to a No) to update the HHRG." Thank you for helping CMS correct this error.